Disabled Dependent Verification Certification

Dental benefits may be extended beyond your plan's normal limiting age for a dependent with a mental or physical disability. This form must be completed by you and the dependent's attending physician.

Member information:

Member name:	Member date of birth:
Delta Dental ID #:	Delta Dental group #:
Disabled dependent name:	Disabled dependent date of birth:

To be completed by attending physician:

I hereby certify that ________________________________ (dependent's name) is not capable of self-support, due to a disability.

______________________________ Physician signature

______________________________ Date

Once completed, please return to Delta Dental.

Mail:
Delta Dental of New Jersey
P.O. 16354
Little Rock, AR 72231

Fax:
973-285-4142

Questions? Please call Customer Service at **800-452-9310.**
Monday - Thursday, 8:00 a.m. – 6:30 p.m.
ET Friday 8:00 a.m. – 5 :00 p.m. ET

06/2021
Delta Dental of New Jersey, Inc.
Delta Dental of Connecticut, Inc.